HB 2389 -- MO HEALTHNET PROGRAM

SPONSOR: Barnes

Beginning July 1, 2018, this bill requires individuals who qualify for coverage under Section 208.151, RSMo, except those who meet the definition of medically frail and participants receiving state supplemental payments for the aged, blind, and disabled, to receive covered services through health plans offered by care management organizations that are authorized by the Department of Social Services under these provisions.

The bill permits the department to designate that certain health care services be excluded from such health plans if it is determined cost effective by the department or based upon population acuity and need. The department may accept regional plan proposals as an additional option for beneficiaries and must advance the development of systems of care for medically complex children who are recipients of MO HealthNet benefits by accepting cost-effective regional proposals from and contracting with appropriate pediatric care networks, pediatric centers for excellence, and medical homes for children to provide MO HealthNet benefits if the department determines it is cost effective to do so.

The bill requires the department to establish uniform utilization review protocols to be used by all authorized health plans. The department must establish a competitive bidding process for contracting with care management organizations. For determining accepted bids, the department must consider the factors as specified in the bill.

Any care management organization that enters into a contract with the state to provide a care management plan must be required to fulfill the terms of the contract and provide such plans for at least 12 months, or longer if the contract so provides. All contracts between care management organizations and the state must include a provision requiring that at least 5% of the payments to the care management organization to be withheld by the department until the end of the contractual period to ensure contractual compliance. The department, at its discretion, may include a contractual provision requiring a withhold amount greater than 5%. The state is prohibited from increasing the reimbursement rate provided to the care management organization during the contract period above the rate included in the contract. If the care management organization breaches the contract, the state must be entitled to bring an action against the care management organization for any remedy allowed by law or equity and must also recover any and all damages provided by law, including liquidated

damages in an amount determined by the department during the bidding process. The department may impose penalties, to be determined by the department, if a contracted care management organization fails to maintain network adequacy, as defined by the department.

Except for individuals who meet the definition of medically frail, participants enrolling in care management plans under these provisions must have the ability to choose their plan. In the enrollment process, a participant must be provided a list of all plans available ranked by the relative actuarial value of each plan and each participant must be informed that he or she will be eligible to receive a portion of the amount saved my Missouri taxpayers if he or she chooses a lower cost plan offered in his or her region. The amount received will be determined by the department according to the department's best judgment as to the portion that will bring the maximum savings to Missouri taxpayers. If a participant fails or refuses to select a plan, the department must determine rules for auto-assignment that must include incentives for low-cost bids and improved health outcomes as determined by the department. These provisions cannot be construed to require the department to terminate any existing care management contract or to extend any care management contract.

The bill requires all MO HealthNet care management plans to provide coverage for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse treatment, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness care, and chronic disease management; pediatric services, including oral and vision care; and any other services required by federal law. No MO HealthNet plan or program may provide coverage for an abortion unless a physician certifies in writing to the MO HealthNet agency that, in the physician's professional judgment, the life of the mother would be endangered if the fetus were carried to term.

Each health plan must be required to provide on a monthly basis all necessary data regarding enrollees, as determined by the department, to allow the department to analyze cost and quality metrics, compliance, and direct potential population health initiative outcomes.

Beginning July 1, 2018, any MO HealthNet participant who elects to receive medical coverage through a private health insurance plan instead of through the MO HealthNet program must be eligible for a private insurance premium subsidy to assist the participant in paying the costs of such private insurance if it is determined to be cost effective by the department. The subsidy must be provided

on a sliding scale based on income, with a graduated reduction in subsidy over a period of time not to exceed two years.